

3791

CERTIFICATE OF DEATH

Reg. Dist. No.

03741

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Victoria Last Abell				4. DATE OF DEATH Month March Day 12, Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1873		9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James B. H. Hammett				14. MOTHER'S MAIDEN NAME Elizabeth Tubman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. INFORMANT Address Mrs Beatrice A. Combs California, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho - Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Coronary Thrombosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3/7/60 3/9/60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 28, 1944 to March 12, 1960 , that I last saw the deceased alive on March 11, 1960 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert V. Fuchs M.D.				ADDRESS (Street, city or town, state) Leonardtown, Md. DATE SIGNED 3/15/60			
PHYSICIAN'S NAME (Type) Robert Fuchs M. D.				Leonardtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/60		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE MAR 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

3731

MASSACHUSETTS
COUNTY OF
CITY OF
DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
AGE
SEX
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
BIRTH
DEATH
BURIAL
INTERVIEW
SIGNATURE
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3804

CERTIFICATE OF DEATH

Reg. Dist. No.

03742

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		c. LENGTH OF STAY IN 1b 10 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Catherine Middle Ann Last Beecham		4. DATE OF DEATH Month March Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Waring		14. MOTHER'S MAIDEN NAME Maria R. Garner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs George S. Barnes Tall Timbers, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary fibrosis and emphysema 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cv disease INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1959 , to Mar 9, 1960 , that I last saw the deceased alive on Mar 3, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md DATE SIGNED 3/18/60			
ACTUAL SIGNATURE Roy L. Luytner M.D.		PHYSICIAN'S NAME (Type) Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/60	
22c. NAME OF CEMETERY OR CREMATORY Christ Church		22d. LOCATION (City, town, or county) (State) Chaptico, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE MAR 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CENTRAL AVE. & DEPT.

RECEIVED STATE OF ARIZONA DEPT. OF HEALTH - BUREAU OF

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3805

CERTIFICATE OF DEATH

Reg. Dist. No.

03743

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island		c. LENGTH OF STAY IN 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Piney Point			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Victoria Last Brown				4. DATE OF DEATH Month March Day 23 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1873		9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Chesser				14. MOTHER'S MAIDEN NAME Annie E. Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT E. Earl Brown Address Piney Point, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Central thrombosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to March 23, 1960 , that I last saw the deceased alive on March 23, 1960 , and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED 3/23/60							
ACTUAL SIGNATURE P. J. Bean M.D.				DATE SIGNED 3/23/60			
PHYSICIAN'S NAME (Type) P. J. Bean M. D.				Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/60		22c. NAME OF CEMETERY OR CREMATORY St. George Island Methodist		22d. LOCATION (City, town, or county) (State) St. George Island, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3806

CERTIFICATE OF DEATH

03744

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MARYS CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MARYS CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA WILMA BULLENS		4. DATE OF DEATH Month Day Year MARCH 10 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 29, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES A. McINTOSH		14. MOTHER'S MAIDEN NAME ANNIE SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT MRS. MYRTLE E. HAINES - ST. MARYS CITY, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema.		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Oct 1, 1960 to March 10, 1960 , that I last saw the deceased alive on March 9, 1960 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Julian S. Lane		ADDRESS (Street, city or town, state) Lexington Park, Md. DATE SIGNED Mayland	
PHYSICIAN'S NAME (Type) Julian S. Lane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/11/60	
22c. NAME OF CEMETERY OR CREMATORY Orange, New Jersey		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR MAR 17 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN 1b Leonardtown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William COLBY				4. DATE OF DEATH Month Mar. Day 13, Year 1960			
5. SEX M		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 12/30/59		9. AGE (In years last birthday) 2 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months 2</td> <td>Days 2 Hours 2 Min. 2</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months 2	Days 2 Hours 2 Min. 2
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months 2	Days 2 Hours 2 Min. 2						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY -----				
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Jack D. Colby				14. MOTHER'S MAIDEN NAME Yvonne Caulking			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Jack D. Colby - Leonardtown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.				DATE SIGNED March 13, 1960			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/60		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery			
22d. LOCATION (City, town, or county) Great Mills, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE MAR 17 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2078 243XV5

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]	
3. AGE [Age]		4. RACE [Race]	
5. DATE OF DEATH [Date]		6. TIME OF DEATH [Time]	
7. PLACE OF DEATH [Place]		8. CAUSE OF DEATH [Cause]	
9. MANNER OF DEATH [Manner]		10. SIGNATURE OF MEDICAL EXAMINER [Signature]	
11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF JURY [Signature]		14. SIGNATURE OF JUDGE [Signature]	
15. SIGNATURE OF CLERK [Signature]		16. SIGNATURE OF REGISTRAR [Signature]	
17. SIGNATURE OF [Other Official] [Signature]		18. SIGNATURE OF [Other Official] [Signature]	
19. SIGNATURE OF [Other Official] [Signature]		20. SIGNATURE OF [Other Official] [Signature]	
21. SIGNATURE OF [Other Official] [Signature]		22. SIGNATURE OF [Other Official] [Signature]	
23. SIGNATURE OF [Other Official] [Signature]		24. SIGNATURE OF [Other Official] [Signature]	
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43. SIGNATURE OF [Other Official] [Signature]		44. SIGNATURE OF [Other Official] [Signature]	
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93. SIGNATURE OF [Other Official] [Signature]		94. SIGNATURE OF [Other Official] [Signature]	
95. SIGNATURE OF [Other Official] [Signature]		96. SIGNATURE OF [Other Official] [Signature]	
97. SIGNATURE OF [Other Official] [Signature]		98. SIGNATURE OF [Other Official] [Signature]	
99. SIGNATURE OF [Other Official] [Signature]		100. SIGNATURE OF [Other Official] [Signature]	

3793

CERTIFICATE OF DEATH

Reg. Dist. No.

03746

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown,				c. LENGTH OF STAY IN 1b 8days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Richard Last Dean				4. DATE OF DEATH Month March Day 18, Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1886	
9. AGE (In years lost birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ? ?				14. MOTHER'S MAIDEN NAME ? ? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217 05 6356			
17. INFORMANT Annie G. Dean				Address Hughesville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from 3/12 , 19 60 , to 3/18 , 19 60 , that I last saw the deceased alive on 3/18 , 19 60 , and that death occurred at 2 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Lexington Park, Maryland			
PHYSICIAN'S NAME (Type) Jullian Lane M. D.				DATE SIGNED 3/21/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/60		22c. NAME OF CEMETERY OR CREMATORY Joy Chapel		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtown, Maryland		24a. RECEIVED BY REGISTRAR MAR 24 60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kinn							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

CERTIFICATE OF ORIGIN

100-100000



1



1
14
078
TO SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

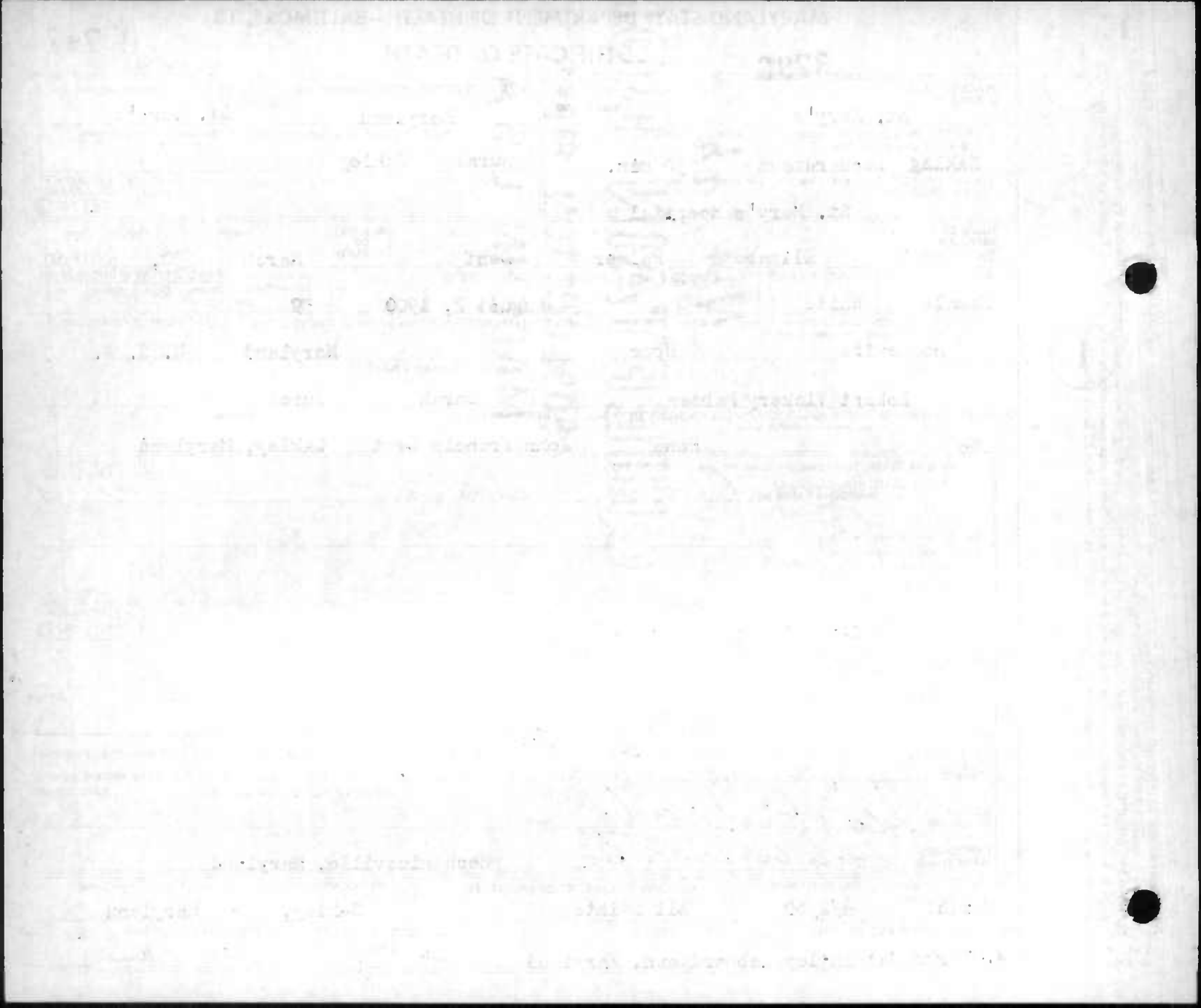
03747

3795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 30 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Palmer Last Dent		4. DATE OF DEATH Month March Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1900
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
10b. KIND OF BUSINESS OR INDUSTRY Home		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Vickery Palmer		14. MOTHER'S MAIDEN NAME Sarah Burch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous coronary		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/30 , 19 60 , to 3/30/60 , 19 60 , that I last saw the deceased alive on 3/30 , 19 60 , and that death occurred at 1:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Maryland DATE SIGNED Leo W. Berube			
ACTUAL SIGNATURE Leo W. Berube		M.D. Leo W. Berube	
PHYSICIAN'S NAME (Type) Leo W. Berube		M.D. Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/60	
22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Oakley, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3794

CERTIFICATE OF DEATH

64945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b 12 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE St. Mary's b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Gough			4. DATE OF DEATH Month Day Year March 11, 19 60		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1960	9. AGE (In years lost birthday) yrs. 11	IF UNDER 1 YEAR Months Days 11 42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Marion Gough, Jr.		14. MOTHER'S MAIDEN NAME Ann Morgan Broun			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown		16. SOCIAL SECURITY NO. Mother		12. CITIZEN OF WHAT COUNTRY? U. S.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Summerville Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Placenta Praevia in mother & Caesarian Section					INTERVAL BETWEEN ONSET AND DEATH 12 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Medley Neck, Md.	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 11 Mar , 19 60 , to 11 Mar , 19 60 , that I last saw the deceased alive on 3 Apr , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE David L. Morrison		ADDRESS (Street, city or town, state) Medley Neck, Md.		DATE SIGNED 3-14-60	
PHYSICIAN'S NAME (Type) Family					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/60		22c. NAME OF CEMETERY OR CREMATORY Our Lady's Chapel	
23. FUNERAL DIRECTOR'S SIGNATURE Family		ADDRESS		22d. LOCATION (City, town, or county) (State) Medley Neck, Md.	
24a. REC'D BY REGISTRAR DATE APR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

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644X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 d, Film G260 4/12/60 iwk

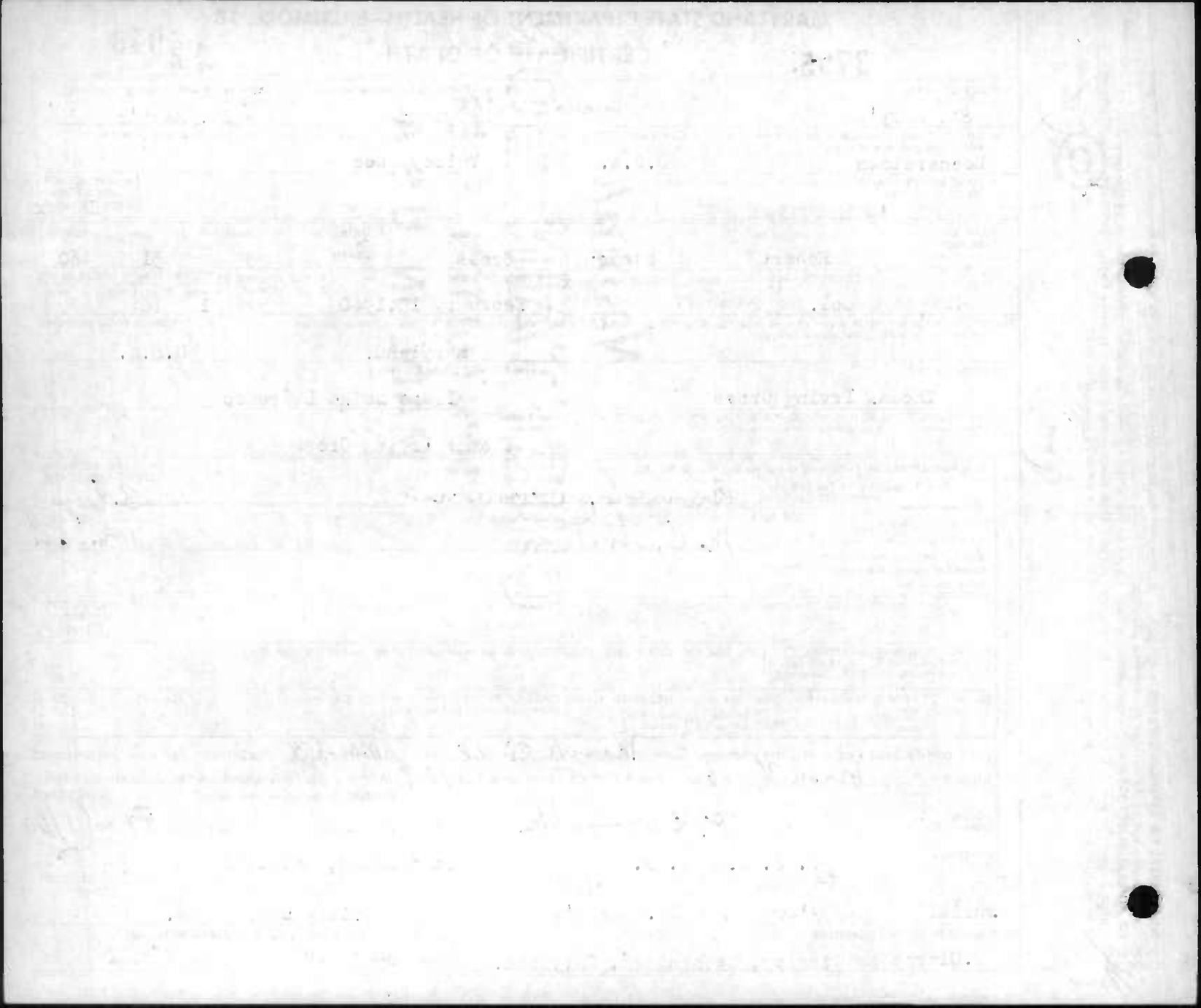
3795

CERTIFICATE OF DEATH

64946
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Steven Last Gross			4. DATE OF DEATH Month 3 Day 31 Year 1960		
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1960		9. AGE (In years last birthday) 1 yrs. 16 Months 1 Days 16 Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
13. FATHER'S NAME Thomas Irving Gross			14. MOTHER'S MAIDEN NAME Irene Letha Lawrence		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. Thomas Irving Gross		INFORMANT Address Thomas Irving Gross	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 28 1960 to March 31, 1960	
20f. (City or town) (County) (State)		21. I certify that attended the deceased from March 28 1960 to March 31, 1960 , that I last saw the deceased alive on March 31, 1960 , and that death occurred at 10:7 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. J. Bean M. D.		ADDRESS (Street, city or town, state) Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/60		22c. NAME OF CEMETERY OR CREMATORY St. George's	
22d. LOCATION (City, town, or county) (State) Valley Lee, Md.		23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown, Maryland.			
24a. REC'D BY REGISTRAR DATE APR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

2078376XV4



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G261 4/13/60 iwk
 3807 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland		c. LENGTH OF STAY IN 1b 4yrs 6months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle S. Last Hammett		4. DATE OF DEATH Month March Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1875
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs John Lancaster		Address St. Mary's City, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 1960 , to March 29, 1960 , that I lost saw the deceased alive on March 28, 1960 , and that death occurred at 47 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE P. J. Bean		DATE SIGNED 5/31/60	
PHYSICIAN'S NAME (Type) P. J. Bean M. D.		Great Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's		22d. LOCATION (City, town, or county) (State) Ridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR APR 11 '60	
ADDRESS Leonardtwn, Maryland		24b. REGISTRAR'S SIGNATURE Charles S. K...	

STATE OF NEW YORK

County of _____

City of _____

State of New York

County of _____

City of _____

State of New York

County of _____

City of _____

State of New York

County of _____

City of _____

State of New York

County of _____

City of _____

State of New York

County of _____

City of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
3803 CERTIFICATE OF DEATH									
Reg. Dist. No. 03748									
1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River			c. LENGTH OF STAY IN 1b 2 1/2 hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital					d. STREET ADDRESS U. S. Naval Air Station			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harlan Leroy HANSON					4. DATE OF DEATH Month Day Year March 17 60				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1939		9. AGE (In years last birthday) 21 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parachute Rigger		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Milford Hanson					14. MOTHER'S MAIDEN NAME Mildred Clausen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 5/56 to 3/60		17. INFORMANT U. S. Navy Records, Address USNAS, Patuxent River, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, subarachnoid and cerebro-ventricular 330X DUE TO recent, massive from artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ruptured congenital aneurysm of the anterior cerebral (c) artery								INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 March , 19 60 , to 17 March , 19 60 , that I last saw the deceased alive on 17 March , 19 60 , and that death occurred at 11:01 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Station Hospital, U.S.N.A.S. DATE SIGNED ACTUAL SIGNATURE James P. Zettas M.D. PHYSICIAN'S NAME (Type) JAMES P. ZETTAS, LT MC USNR Patuxent River, Maryland 3/17/60									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/60		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) Thief River Falls, Minnesota		
23. FUNERAL DIRECTOR'S SIGNATURE Sending Funeral Home					ADDRESS Thief River Falls, Minn.		24a. REC'D BY REGISTRAR DATE MAR 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kravitz

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF RESIDENT HEALTH—BALTIMORE, 18

Items 1, 14 Film G258 3-15-60 et

03749

3809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Scotland c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 18 D.C. b. COUNTY X Washington, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Leonard Last Herbert		4. DATE OF DEATH Month March Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ?
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.A.S.	
13. FATHER'S NAME Clarence C. Herbert		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs Alberta Wathen 2806 N St.S.E.Washington,D.C	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized arterio sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hours 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 56 , to March 2 , 19 60 , that I last saw the deceased alive on March 2 1960 , and that death occurred at 10a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED March 3/60 ACTUAL SIGNATURE P.J.Bean M.D. PHYSICIAN'S NAME (Type) P.J.Bean M.D. Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.Clarke Mattingley ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE MAR 10 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

RECEIVED

1902

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3797

CERTIFICATE OF DEATH

03750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtowntown			c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Charlotte Hall				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Levi Last Holley				4. DATE OF DEATH Month March Day 9, Year 19 60					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 22, 1959			
9. AGE (In years lost birthday) yrs. 10		IF UNDER 1 YEAR Months 10 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
						12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert James Holley				14. MOTHER'S MAIDEN NAME Mary Catherine Chapman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT Address Father			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 22, 1959 , to Mar 9, 1960 , that I last saw the deceased alive on Mar 2, 1960 , and that death occurred at 7:55 M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Mechanicsville, Maryland	
ACTUAL SIGNATURE <i>Ray G. Guther</i>				M.D. <i>Mechanicsville</i>				DATE SIGNED	
PHYSICIAN'S NAME (Type)				Mechanicsville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/60		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtowntown, Maryland		24a. REC'D BY REGISTRAR DATE MAR 15 '60			
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4000366XVS

CERTIFICATE OF DEATH

1975

(2)

Dec. 1975

U.S. Social Security

James Earl Ray

1928-1968

Memphis, Tennessee

James Earl Ray

1928-1968

Memphis, Tennessee

James Earl Ray

1928-1968

Memphis, Tennessee

James Earl Ray

1928-1968

Memphis, Tennessee

James Earl Ray

1928-1968

Memphis, Tennessee

James Earl Ray

1928-1968

Memphis, Tennessee

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03751

3810

Item 14, Film G260 4/11/60 18

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Charlotte Hall</u>		c. LENGTH OF STAY IN 1b <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Charlotte Hall</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Patuxent River Road</u>				d. STREET ADDRESS <u>Cremona Farm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Eugene</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 April 1924</u>		9. AGE (In years last birthday) <u>35</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Aviator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>Violet Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>7/43 - 3/60</u>		17. INFORMANT <u>Official U.S. Navy Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POISONING, GAS, CARBON MONOXIDE</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hose attached to exhaust leading to interior of automobile.</u>					
20c. TIME OF INJURY Month, Day, Year <u>6 - 10</u> Hour <u>XX</u> p. m. <u>Mar. 25</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Patuxent River Road, St. Mary's Co., Md.</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>1. Asphyxiation</u> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. S. WRAY, Captain MC, U.S. Navy</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Wm. D. BOYD, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brainerd, Minnesota</u>		22d. LOCATION (City, town, or county) (State) <u> </u> <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halverson-Johnson Brainerd, Minnesota</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCASION OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF EXAMINER [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF CORONER [Faint text]	
13. SIGNATURE OF JURY [Faint text]		14. SIGNATURE OF JURY [Faint text]		15. SIGNATURE OF JURY [Faint text]	
16. SIGNATURE OF JURY [Faint text]		17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JURY [Faint text]	
19. SIGNATURE OF JURY [Faint text]		20. SIGNATURE OF JURY [Faint text]		21. SIGNATURE OF JURY [Faint text]	
22. SIGNATURE OF JURY [Faint text]		23. SIGNATURE OF JURY [Faint text]		24. SIGNATURE OF JURY [Faint text]	
25. SIGNATURE OF JURY [Faint text]		26. SIGNATURE OF JURY [Faint text]		27. SIGNATURE OF JURY [Faint text]	
28. SIGNATURE OF JURY [Faint text]		29. SIGNATURE OF JURY [Faint text]		30. SIGNATURE OF JURY [Faint text]	
31. SIGNATURE OF JURY [Faint text]		32. SIGNATURE OF JURY [Faint text]		33. SIGNATURE OF JURY [Faint text]	
34. SIGNATURE OF JURY [Faint text]		35. SIGNATURE OF JURY [Faint text]		36. SIGNATURE OF JURY [Faint text]	
37. SIGNATURE OF JURY [Faint text]		38. SIGNATURE OF JURY [Faint text]		39. SIGNATURE OF JURY [Faint text]	
40. SIGNATURE OF JURY [Faint text]		41. SIGNATURE OF JURY [Faint text]		42. SIGNATURE OF JURY [Faint text]	
43. SIGNATURE OF JURY [Faint text]		44. SIGNATURE OF JURY [Faint text]		45. SIGNATURE OF JURY [Faint text]	
46. SIGNATURE OF JURY [Faint text]		47. SIGNATURE OF JURY [Faint text]		48. SIGNATURE OF JURY [Faint text]	
49. SIGNATURE OF JURY [Faint text]		50. SIGNATURE OF JURY [Faint text]		51. SIGNATURE OF JURY [Faint text]	
52. SIGNATURE OF JURY [Faint text]		53. SIGNATURE OF JURY [Faint text]		54. SIGNATURE OF JURY [Faint text]	
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58. SIGNATURE OF JURY [Faint text]		59. SIGNATURE OF JURY [Faint text]		60. SIGNATURE OF JURY [Faint text]	
61. SIGNATURE OF JURY [Faint text]		62. SIGNATURE OF JURY [Faint text]		63. SIGNATURE OF JURY [Faint text]	
64. SIGNATURE OF JURY [Faint text]		65. SIGNATURE OF JURY [Faint text]		66. SIGNATURE OF JURY [Faint text]	
67. SIGNATURE OF JURY [Faint text]		68. SIGNATURE OF JURY [Faint text]		69. SIGNATURE OF JURY [Faint text]	
70. SIGNATURE OF JURY [Faint text]		71. SIGNATURE OF JURY [Faint text]		72. SIGNATURE OF JURY [Faint text]	
73. SIGNATURE OF JURY [Faint text]		74. SIGNATURE OF JURY [Faint text]		75. SIGNATURE OF JURY [Faint text]	
76. SIGNATURE OF JURY [Faint text]		77. SIGNATURE OF JURY [Faint text]		78. SIGNATURE OF JURY [Faint text]	
79. SIGNATURE OF JURY [Faint text]		80. SIGNATURE OF JURY [Faint text]		81. SIGNATURE OF JURY [Faint text]	
82. SIGNATURE OF JURY [Faint text]		83. SIGNATURE OF JURY [Faint text]		84. SIGNATURE OF JURY [Faint text]	
85. SIGNATURE OF JURY [Faint text]		86. SIGNATURE OF JURY [Faint text]		87. SIGNATURE OF JURY [Faint text]	
88. SIGNATURE OF JURY [Faint text]		89. SIGNATURE OF JURY [Faint text]		90. SIGNATURE OF JURY [Faint text]	
91. SIGNATURE OF JURY [Faint text]		92. SIGNATURE OF JURY [Faint text]		93. SIGNATURE OF JURY [Faint text]	
94. SIGNATURE OF JURY [Faint text]		95. SIGNATURE OF JURY [Faint text]		96. SIGNATURE OF JURY [Faint text]	
97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]		99. SIGNATURE OF JURY [Faint text]	
100. SIGNATURE OF JURY [Faint text]		101. SIGNATURE OF JURY [Faint text]		102. SIGNATURE OF JURY [Faint text]	

3798

CERTIFICATE OF DEATH

03752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle R. Last Jones		4. DATE OF DEATH Month March Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1916
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 4 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Butler Taylor		14. MOTHER'S MAIDEN NAME Ida V. Beale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. William Butler Lexington Park, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension; Malignant DUE TO (c) 4-6 Months INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17th and , 19 60 , to 15 Mar , 19 60 , that I last saw the deceased alive on 14 March , 19 60 , and that death occurred at 7:49 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lexington Park, Maryland DATE SIGNED Ernest D. Rehm			
ACTUAL SIGNATURE Ernest D. Rehm M.D.		PHYSICIAN'S NAME (Type) Ernest Rehm M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Face		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR MAR 17 '60	
ADDRESS Leonardtwn, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]
6. [illegible]

7. [illegible]
8. [illegible]
9. [illegible]

10. [illegible]
11. [illegible]
12. [illegible]

13. [illegible]
14. [illegible]
15. [illegible]

16. [illegible]
17. [illegible]
18. [illegible]

19. [illegible]
20. [illegible]
21. [illegible]

22. [illegible]
23. [illegible]
24. [illegible]

25. [illegible]
26. [illegible]
27. [illegible]

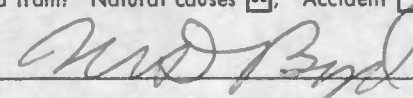
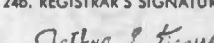
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03753

Reg. Dist. No.

3811

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jonathon Middle Ray Last Lawrence				4. DATE OF DEATH Month March Day 26 Year 1960							
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1960		9. AGE (In years last birthday) yrs. 2 Months 4 Days 4 Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Runder				14. MOTHER'S MAIDEN NAME Edith Marie Lawrence							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) William D. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3/26/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/60		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR DATE MAR 31 '60		24b. REGISTRAR'S SIGNATURE 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)

SM 9/55

4000 22 4XV3

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Mary's City		c. LENGTH OF STAY IN 1b 43 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural St. Mary's City		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle Elizabeth Last Milburn		4. DATE OF DEATH Month March Day 31 Year 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 15, 1891		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Columbus Oliver Adams	
14. MOTHER'S MAIDEN NAME Mary Indiana Edwards		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr Mark Milburn		Address St. Mary's City, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of head of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) none DUE TO (c) none		INTERVAL BETWEEN ONSET AND DEATH 6 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1960 to March 31, 1960 , that I last saw the deceased alive on 3/31/1960 and that death occurred at 2 P.M. from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) St. Mary's City, Md.		DATE SIGNED 3/31/60		ACTUAL SIGNATURE Julian S. Lane		PHYSICIAN'S NAME (Type) Julian S. Lane	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/60		22c. NAME OF CEMETERY OR CREMATORY Trinity Church Cemetery		22d. LOCATION (City, town, or county) (State) St. Mary's City, Md.		23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley	
ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume		24c. DATE APR 5 '60		24d. SIGNATURE	

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3813

CERTIFICATE OF DEATH

Reg. Dist. No.

03755

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chaptico		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL Chaptico		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Nelson				4. DATE OF DEATH Month March Day 10 Year 19 60			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1873	9. AGE (In years lost birthday) yrs. 86	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Richard Butler				14. MOTHER'S MAIDEN NAME ???			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		INFORMANT Address Joseph S. Nelson Chaptico, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2d			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 March 1960 to March 1960 , that I lost saw the deceased alive on 9 March 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Leon W. Benke M.D.							
PHYSICIAN'S NAME (Type) Mechanicsville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/60		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE MAR 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bluette Middle Last Pannell		4. DATE OF DEATH Month March Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE Oligored	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hamilton Robinson		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Informant Address Hospital Records	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Inanition Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Ca of aorto sigmoid (c) Congestive Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcohol abuse - Sarcosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 20 , 19 60 , to Mar 20 , 19 60 , that I last saw the deceased alive on 20 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE David L. Pannell M.D.		ADDRESS (Street, city or town, state) Mechanicsville, Maryland DATE SIGNED 2-13-60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/24/60	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR MAR 31 '60	
ADDRESS Leonardtown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Knaub	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3800

CERTIFICATE OF DEATH

03757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Lawrence Last Quade		4. DATE OF DEATH Month March Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1906
9. AGE (In years last birthday) 54 yrs.		10. UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.	11. UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Joseph Quade		14. MOTHER'S MAIDEN NAME Mary Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs Alice M. Quade Bushwood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Hemorrhage - multiple - subcut etc. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenia (c) Carcinoma prostate & metastases 3 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 wk 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 57 , 19 to Mar 9 , 1960, that I last saw the deceased alive on Mar 9 , 1960 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. Roy Guyther M.D.		PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/60	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR MAR 15 '60	
ADDRESS Leonardtwn, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

078

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DP

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3800

5

1912

1912

1912

1912

1912

1912

1912

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Usual Residence

Place of Death

Cause of Death

Manner of Death

Time of Death

Place of Burial

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

3814

CERTIFICATE OF DEATH

03758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEACHVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEACHVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL				d. STREET ADDRESS RURAL			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ALLEN Last RIDGELL				4. DATE OF DEATH Month MARCH Day 4 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1903		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT RIDGELL				14. MOTHER'S MAIDEN NAME LULLA NORRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MRS. HATTIE RIDGELL Address BEACHVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year 15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1945 , to March 4, 1960 , that I last saw the deceased alive on March 4, 1960 , and that death occurred at 11 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) GREAT MILLS, Md. DATE SIGNED 3/5/60							
ACTUAL SIGNATURE P.J. BEAN		M.D. GREAT MILLS, Md.					
PHYSICIAN'S NAME (Type) P.J. BEAN, MD		GREAT MILLS, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/8/60		22c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS		22d. LOCATION (City, town, or county) (State) RIDGE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. ROBINSON - LEONARDTOWN, Md.				24a. REC'D BY REGISTRAR MAR 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death., Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3815

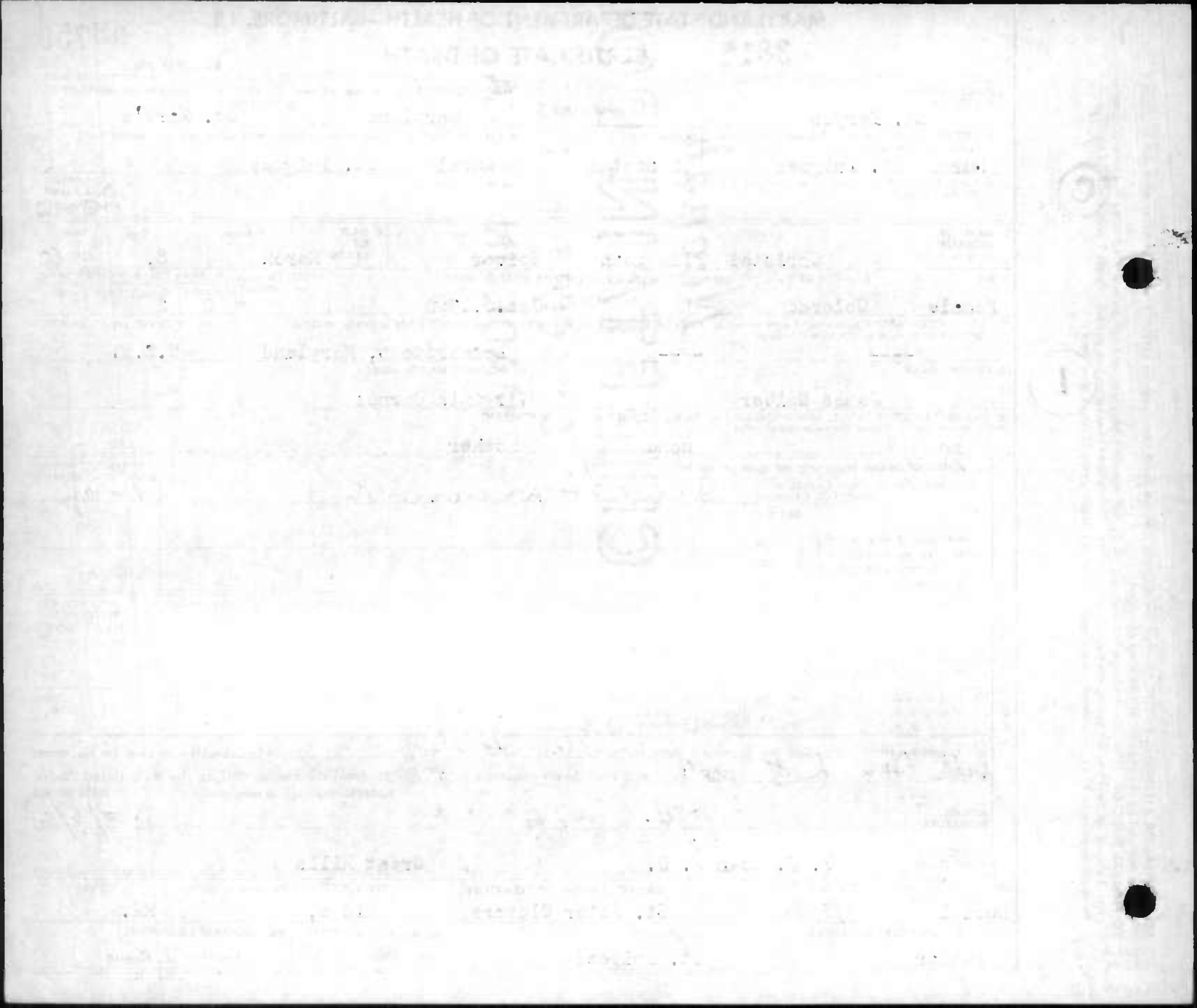
CERTIFICATE OF DEATH

03759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St. Inigoes</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Christal Elizabeth</u> Middle <u>Spicer</u> Last <u>Spicer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>19 60</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1960</u>
9. AGE (In years lost birthday) yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>Min.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Leonardtown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Spicer</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. ADDRESS <u>Informant</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____ to _____, 19 _____, that I last saw the deceased alive on _____, 19 _____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) <u>P. J. Bean M. D.</u> <u>Great Mills</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter Clavers</u>		22d. LOCATION (City, town, or county) (State) <u>Ridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Father</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

2078245XV3



CERTIFICATE OF DEATH

Reg. Dist. No.

3801

64952

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 5 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Thompson		4. DATE OF DEATH Month March Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1960
9. AGE (In years lost birthday) yrs. 5		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Turner Berry		14. MOTHER'S MAIDEN NAME Estelle Louise Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Estelle Louise Thompson California, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature (4 months) 776X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 30, 1960 , to March 30, 1960 , that I last saw the deceased alive on March 30, 1960 , and that death occurred at 6 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/31/60			
ACTUAL SIGNATURE W. Clarke Mattingley		PHYSICIAN'S NAME (Type) W. Clarke Mattingley	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60	
22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE APR 7 '60	
24b. REGISTRAR'S SIGNATURE Robert A. Thoms			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1078314XV0

STATE OF NEW YORK

1935

IN SENATE
January 15, 1935
REPORT
OF THE
COMMISSIONER OF HEALTH
AND
MEMBERS OF THE
BOARD OF HEALTH
FOR THE YEAR
1934
ALBANY:
J.B. LIPPINCOTT COMPANY
1935

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G260 4/11/60 1b

3802

CERTIFICATE OF DEATH

03760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle DELL Last VAUSE				4. DATE OF DEATH Month MARCH Day 27 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12, 1888		9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) VERMONT		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WARREN D. HEATH				14. MOTHER'S MAIDEN NAME MARY J. CORRAUTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT GEO. E. VAUSE - LEONARDTOWN, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1960 , to March 27, 1960 , that I last saw the deceased alive on March 26, 1960 , and that death occurred at 9 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Greenwell				ADDRESS (Street, city or town, state) LEONARDTOWN, MARYLAND		DATE SIGNED 3/28/60	
PHYSICIAN'S NAME (Type) CHARLES GREENWELL, MD				LEONARDTOWN, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/30/60		22c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY		22d. LOCATION (City, town, or county) (State) GREAT MILLS, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. ROBINSON				ADDRESS LEONARDTOWN, MARYLAND		24a. REC'D BY REGISTRAR APR 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03761

3803

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST. MARYS		STATE MARYLAND		STATE MARYLAND		COUNTY ST. MARYS	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN LEONARDTOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN MECHANICSVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ST. MARYS HOSPITAL				STREET ADDRESS (If rural give location) RURAL			
3. NAME OF DECEASED (Type or Print) INFANT GIRL ZIMMERMAN				4. DATE OF DEATH (Month) (Day) (Year) 3 / 7 / 19 60			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH 3/7/60	9. AGE last birthday 0 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AMMON S. ZIMMERMAN				14. MOTHER'S MAIDEN NAME ANNA S. STAUFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS ANNA S. ZIMMERMAN - MECHANICSVILLE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776x IMMEDIATE CAUSE (A) Prematurity						INTERVAL BETWEEN ONSET AND DEATH 20 min	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 7</u>, 19<u>60</u>, to <u>Mar 7</u>, 19<u>60</u>, that I last saw the deceased alive on <u>Mar 7</u>, 19<u>60</u>, and that death occurred at <u>1 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE Leon W. Berube, MD		ADDRESS (Street, city, town, state) Mechanicsville, Md.		DATE SIGNED 3/7/60			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 3/8/60		NAME OF CEMETERY OR CREMATORY Stauffer Mennoite Cem.		LOCATION (City, town, or county) (State) LOVEVILLE, Md.	
24. REC'D BY REGISTRAR MAR 10 '60		REGISTRAR'S SIGNATURE Arthur S. Jones		25. FUNERAL DIRECTOR'S SIGNATURE P.B. ROBINSON		ADDRESS LEONARDTOWN, Md.	

2078266XV0

Mar 4/60

CERTIFICATE OF DEATH

Reg. No. 100

ALL DEATHS MUST BE REPORTED TO THE REGISTRAR

38-3

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Jan 15, 1945		Boston, Mass.		Boston, Mass.		Heart Disease		Natural		[Signature]	
11. Name of Informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Signature of Informant		18. Date		19. Signature of Physician		20. Date	
Jane Doe		Wife		123 Main St.		Boston		Mass.		02101		[Signature]		Jan 16, 1945		[Signature]		Jan 16, 1945	

MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING
BUREAU OF VITAL RECORDS
100 STATE STREET, ROOM 100
BOSTON, MASSACHUSETTS 02109
TELEPHONE 522-1234
FAX 522-5678
HOURS: 9:00 AM - 5:00 PM
COST: \$10.00 per copy
REMARKS: This certificate is valid for all purposes.
It is the duty of every citizen to report a death to the Registrar.
Failure to do so is a crime under the laws of the Commonwealth.
The Registrar will issue a certificate of death only if the death has been properly reported.
The certificate of death is a legal document and must be kept for your records.
It is recommended that you keep a copy of the certificate of death in a safe place.
The Registrar will provide a copy of the certificate of death to you if you request it.
The cost of a copy of the certificate of death is \$10.00.
The Registrar will provide a copy of the certificate of death to you if you request it.
The cost of a copy of the certificate of death is \$10.00.